Section 3.14 Securing Services and Prior Authorization

3.14.1 Introduction

It is important that persons receiving behavioral health services have timely access to the most appropriate services. It is also important that limited behavioral health resources are allocated in the most efficient and effective ways possible. Prior authorization processes are typically used to promote appropriate utilization of behavioral health services while effectively managing associated costs. Except during an emergency situation, ADHS/DBHS requires prior authorization before accessing inpatient services in a licensed (OBHL) Level I facility (a psychiatric acute hospital, a residential treatment center for persons under the age of 21 or a sub-acute facility). In addition, a Regional Behavioral Health Authority (RBHA) may require prior authorization of covered behavioral health services other than inpatient services with the prior written approval of ADHS/DBHS.

Behavioral health services can be accessed for a person by one of two ways:

Securing Most Behavioral Health Services:

- Most behavioral health services do not require prior authorization. Based upon the recommendations and decisions of the child and family team or clinical team, services will be secured for any and all covered services that address the needs of the person and family. During the treatment planning process, the Child and Family Team (CFT), or treatment team for adults, may use established tools to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the person. Child and Family Teams and treatment teams should make decisions based on a person's identified needs and should not use these tools as criteria to deny or limit services.

Securing Services that Need Prior Authorization:

- Prior authorization is required for certain covered behavioral health services. Behavioral health services requiring prior authorization include:
  - Non-Emergency admissions to an OBHL Level I facility;
  - Continued stay in an OBHL Level I facility;

- OBHL Level II behavioral health residential facilities (Tribal RBHAs); and
- [**Add RBHA services that require prior authorization as approved by ADHS/DBHS**]

When it is determined that a person is in need of behavioral health services requiring prior authorization, a behavioral health professional applies designated authorization and continued stay criteria to approve the provision of the covered service. A decision to deny a prior authorized service must be made by the RBHA Medical Director or physician designee.

This section is intended to present the distinctions between prior authorization of select behavioral health services and the securing of all other behavioral health services and:
- To describe Federal requirements associated with authorization and denial of inpatient services;
- To clearly identify what covered services must be prior authorized; and
- To clearly articulate how to access a covered behavioral health service that does not require prior authorization.

3.14.2 References
The following citations can serve as additional resources for this content area:
- 42 CFR 441 Subpart D
- 42 CFR 456 Subparts C and D
- 42 CFR 438.114
- 9 A.A.C. 20
- R9-22-210
- R9-22-1205
- R9-31-210
- R9-31-1205
- AHCCCS/ADHS Contract
- ADHS/T/RBHA Contract
- Complaints and Appeals Section
- Grievance and Request for Investigation for Persons Determined to have a Serious Mental Illness (SMI) Section
- Grievance and Member Notice Requirements Section
- Medication Formulary Section
- Child and Family Team Practice Improvement Protocol
- The ADHS/DBHS System Principles

3.14.3 Scope
To whom does this apply?
All persons that receive behavioral health services.

3.14.4 Objectives
To ensure that behavioral health services are secured or prior authorized:
- Consistent with the Arizona Principles for persons receiving services through the public behavioral health system; and
- According to Federal, state and T/RBHA requirements; and

- To ensure timely access to care.

3.14.5 Did you know?

- It is important for a behavioral health professional to document enough information in the comprehensive clinical record to validate that the prior authorization request meets all elements of the authorization criteria.
- The T/RBHA may require prior authorization of behavioral health services other than inpatient services only with the prior written approval of ADHS/DBHS.
- That a Title XIX eligible person that is receiving services in a Level I residential treatment center who turns age 21 may continue to receive services until the point in time in which services are no longer required or the person turns age 22, whichever comes first.
- Prior authorization criteria may not include any one of the following as a sole criteria for denial of services:
  - Lack of family involvement,
  - Presence or absence of a particular mental health diagnosis or
  - Presence of substance use, abuse or dependence

3.14.6 Definitions

Behavioral Health Professional

Certification of Need (CON)

Child and Family Team

Denial

Emergency Behavioral Health Services

Inpatient Services

Level I Facility

Medically Necessary Covered Services

Prior authorization

Psychiatric Acute Hospital

Recertification of Need (RON)

Residential Treatment Center (RTC)

Sub-Acute Facility

3.14.7 Procedures

3.14.7-A: Securing services that do not require prior authorization

Who can secure behavioral health services that do not require prior authorization?
The person's treatment team or the child and family team will secure needed services through the clinical liaison on the team. The child and family team or the clinical team should frame requests for services based on the intensity of service needs, rather than on predetermined, specific services.

What is the purpose of a utilization review process?
Behavioral health providers may choose to adopt tools, such as service planning guidelines, to retrospectively review the utilization of services. The goals of utilization review include:

- Detection of over and under utilization of services;
- Defining expected service utilization patterns;
- Facilitating the examination of practitioners and child and family teams or clinical teams that are effectively allocating services; and
- Identify practitioners and behavioral health providers who could benefit from technical assistance.

[T/RBHA insert specific language here]

3.14.7-B: Accessing services that require prior authorization

What does prior authorization do?
Prior authorization seeks to ensure that persons are treated in the most appropriate, least restrictive and most cost effective setting, with sufficient intensity of service and supervision to safely and adequately treat the person's behavioral health condition. When a person initiates a request through a behavioral health provider for a service requiring prior authorization, the treatment team must immediately forward the request to the personnel responsible for making prior authorization decisions.

When is prior authorization available?
RBHAs or behavioral health providers must have staff available 24 hours a day, seven days a week to receive requests for any service that requires prior authorization.

What about emergencies?
Prior authorization must never be applied in an emergency situation. A retrospective review may be conducted after the person's immediate behavioral health needs have been met. If upon review of the circumstances, the behavioral health service did not meet admission authorization criteria, payment for the service may be denied.

What is a certification of need (CON)?
A CON is a certification made by a physician that inpatient services are or were needed at the time of the person's admission. Although a CON must be submitted prior to a person's admission (except in an emergency), a CON is not an authorization tool designed to approve or deny an inpatient service, rather it is a Federally required attestation by a physician that

inpatient services are or were needed at the time of the person's admission. The decision to authorize a service that requires prior authorization is determined through the application of admission and continued stay authorization criteria. In the event of an emergency, the CON must be submitted within 72 hours of admission. For a sample CON form, see PM Form 3.14.1.

What is a re-certification of need (RON)?
A RON is a re-certification made by a physician, nurse practitioner or physician assistant that inpatient services are still needed for a person. A RON must be completed at least every 60 days for a person who is receiving services in a Level I facility. An exception to the 60-day timeframe exists for inpatient services provided to persons under the age of 21. The treatment plan (individual plan of care) for persons under the age of 21 in a Level I facility must be completed and reviewed every 30 days. The completion and review of the treatment plan in this circumstance meets the requirement for the re-certification of need. For a sample RON form, see PM Form 3.14.2.

What must be documented on a CON or Recertification of Need (RON)?
The following documentation is needed on a CON and RON:

- Proper treatment of the person's behavioral health condition requires services on an inpatient basis under the direction of a physician;
- The service can reasonably be expected to improve the person's condition or prevent further regression so that the service will no longer be needed;
- Outpatient resources available in the community do not meet the treatment needs of the person; and
- CONs, a dated signature by a physician;
- RONs, a dated signature by a physician, nurse practitioner or physician assistant.

Additional CON requirements
- If a person becomes eligible for Title XIX or Title XXI services while receiving inpatient services, the CON must be completed and submitted to [**RBHA indicate here if this requirement is delegated to provider**] prior to the authorization of payment.
- For persons under the age of 21 receiving inpatient services:
  - Federal rules set forth additional requirements for completing CONs when persons under the age of 21 are admitted to, or are receiving services in a Level I facility. These requirements include the following:
    - The CON must be completed by a team that is independent of the facility and must include a physician who has knowledge of the person's situation and who is competent in the diagnosis and treatment of mental illness, preferably child psychiatry; and
    - For persons who are admitted and then become Title XIX or Title XXI eligible while at the facility, the team responsible for the treatment plan must complete the CON. The CON must cover any period of time for which claims for payment are made.

What criteria are used to determine whether to approve or deny a service that requires prior authorization?

For inpatient services, ADHS/DBHS has developed the following criteria to be used by all T/RBHAs and behavioral health providers:

- ADHS/DBHS Admission to Inpatient Services Authorization Criteria (PM Form 3.14.3); and
- ADHS/DBHS Continued Inpatient Services Authorization Criteria (PM Form 3.14.4).

[RBHA insert specific references to and ability to access ADHS/DBHS approved authorization and continued authorization criteria for all other services subjected to prior authorization]

What happens if a person is ready to leave a Level I Facility but there is not an alternative placement available?
If a person receiving inpatient services no longer requires services on an inpatient basis, but services suitable to meet the person's behavioral health needs are not available or the person cannot return to the person's residence because of a risk of harm to self or others, services may continue to be authorized as long as there is an ongoing, active attempt to secure a suitable discharge placement or residence.

3.14.7-C: What are the "rules" for prior authorization? (See Table on next page.)

3.14.7-C: "Rules" for Prior Authorization		
Questions	**Behavioral Health Provider Contracted by a RBHA**	**Behavioral Health Provider Contracted by a TRBHA**
What services must be prior authorized?	Non-emergency admission to and continued stay in an inpatient facility.	
	[**Add other services that require prior authorization by the RBHA**]	Admission and continued stay in a Level II behavioral health facilitiy
Who makes prior authorization decisions?	A behavioral health professional is required to prior authorize services unless it is a decision to deny. A decision to deny must be made by the T/RBHA Medical Director or physician designee.	
How is prior authorization applied inemergency admission?	Prior Authorization must never be applied in an emergency situation.	
What are the considerations for denials?	A denial of a request for admission to or continued stay in an inpatient facility can only be made by the RBHA's Medical Director or physician designee after verbal or written collaboration with the requesting clinician.	A denial of a request for admission to or continued stay in an inpatient facility can only be made by the ADHS/DBHS Medical Director or physician designee after verbal or written collaboration with the requesting clinician.
	When requests for prior authorization are denied or at the time an authorization period expires, the **[RBHA indicate here if this requirement is delegated to provider]** must provide notice of the decision. The RBHA or provider must furnish the person or persons requesting services notice, include the reason for denial in ordinary language and document in the clinical record that notice was provided to the person.	When requests for prior authorization are denied, ADHS/DBHS must provide notice of the decision as required in ADHS/DBHS Policy 2.32, Notice Requirements.
	Before a final decision to deny is made, the person's attending psychiatrist can ask for a reconsideration and present additional information.	
	The RBHA or provider **[RBHA indicate here if this requirement is delegated to provider]** must ensure 24-hour access to a delegated psychiatrist or other physician designee for any denials of inpatient admission.	Upon denial of a prior authorized service by the ADHS/DBHS Medical Director or physician designee, a letter is sent to providers notifying that the service was denied and the reason(s) for the denial.

3.14.7-C: "Rules" for Prior Authorization		
Questions	**Behavioral Health Provider Contracted by a RBHA**	**Behavioral Health Provider Contracted by a TRBHA**
What documentation must be submitted to obtain a prior authorization and what are the timeframes for making a decision?	For requests for admission [RBHA insert language here.] Timelines for making prior authorization decisions Decisions to prior authorize inpatient admission must be made: Within one hour of the request for a psychiatric acute hospital or sub-acute facility; Within 24 hours of the request for a residential treatment center for persons under the age of 21. [**RBHA add timeframes for other ADHS/DBHS approved services that require prior authorization**] Requests for continued stay [**RBHA insert language here**.] Timelines for submitting a request for continued stay [**RBHA insert language here.]**	For requests for admission Prior to an admission, Monday through Friday 8:00 am to 5:00 pm; or within 24 hours of an admission made after 5:00 pm Monday through Friday, on weekends or State holidays the following must be submitted to the Arizona Department of Health Services/Division of Behavioral Health Services/Bureau of Quality Management and Evaluation (Facsimile number 364-4749): A CON, the prior authorization request form (PM Form 3.14.3) and the treatment plan/individual plan of care. Authorization cannot be provided without all the required documentation. For services provided after hours, on weekends or on State holidays, prior authorization must be obtained on the next business day. A provider may also telephone the Bureau of Quality Management and Evaluation at (602) 364-4645. After hours (after 5:00 pm Monday through Friday, on weekends or State holidays) a voice message can be left at the same number and the call will be returned the next business day. Prior authorization is not required for Non-Title XIX/XXI individuals. If Title XIX or Title XXI eligibility is determined during the hospitalization, providers may request retrospective authorization. For retro-authorization to occur, a provider must submit a CON and treatment plan/individual plan of care to the Bureau of Quality Management and Evaluation by the next business day following the person's Title XIX or Title XXI eligibility determination. Timelines for making a prior authorization decision Prior authorization decisions for non-emergency admissions to Level I and Level II facilities will be made within 24 hours of notification or, if a weekend or State holiday, the next business day.

3.14.7-C: "Rules" for Prior Authorization		
Questions	**Behavioral Health Provider Contracted by a RBHA**	**Behavioral Health Provider Contracted by a TRBHA**
		For requests for continued stay A RON, the prior authorization request form (PM Form 3.14.3) and the treatment plan/individual plan of care must be submitted to the Arizona Department of Health Services/Division of Behavioral Health Services/Bureau of Quality Management and Evaluation (Facsimile number 364-4749). Timelines for submitting a request for continued stay Psychiatric acute hospital and sub-acute facility: The initial authorization is valid for 72 hours. A request for continued stay authorization must be submitted within the initial 72 hours or, if on a weekend or State holiday, the request for continued stay authorization must be submitted the next business day. All subsequent continued stay authorizations must be made prior to the expiration of the last authorization. Level I and Level II residential treatment centers: The initial authorization is valid for 30 days. A request for continued stay authorization must be submitted two weeks prior to the expiration of the current authorization.

3.14.7-D: Prior authorizing medications

Upon approval by ADHS/DBHS, a RBHA may require prior authorization for specified medications. If a RBHA or behavioral health provider **[RBHA indicate here if this requirement is delegated to provider]** requires prior authorization for medications, the following requirements must be met:

- Adherence to all the prior authorization requirements outlined in this section, including:
  - Prior authorization availability 24 hours a day, seven days a week;
  - Assurance that a person will not experience a gap in access to prescribed medications due to a change in prior authorization requirements. RBHAs and behavioral health providers must ensure continuity of care in cases in which a medication that previously did not require prior authorization must now be prior authorized; and
  - Incorporation of notice requirements when medication requiring prior authorization is denied, suspended or terminated.

3.14.7-E: Coverage and payment of emergency behavioral health services

The following conditions apply with respect to coverage and payment of emergency behavioral health services for persons that are Title XIX or Title XXI eligible:

- Emergency behavioral health services must be covered and reimbursement made to providers that furnish the services regardless if the provider has a contract with a T/RBHA;
- Payment must not be denied if:
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  - A person who has had an emergency behavioral health condition, including cases in which the absence of medical attention would not have resulted in:
    - Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part.
  - A RBHA or behavioral health provider instructs a person to seek emergency behavioral health services;

- Emergency behavioral health conditions must not be limited to a list of diagnoses or symptoms;
- A RBHA may not refuse to cover emergency behavioral health services based on the failure of a provider to notify the RBHA of a person's screening and treatment within 10 calendar days of presentation for emergency services. A person who has an emergency behavioral health condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the person.
- The attending emergency physician, or the provider actually treating the person, is responsible for determining when the person is sufficiently stabilized for transfer or discharge, and such determination is binding on the RBHA.